DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST IDR

PRINTED: 06/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #2	445099	A. BUILDING _____ B. WING _____	C 05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, ATHENS	1204 FRYE ST ATHENS, TN 37303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Statement of Deficiencies AMENDED 06/19/12.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide confidentiality of	F 164	This plan is submitted as required under State and Federal Law. The submission of this plan does not constitute an admission on the part of NHC Healthcare, Athens as to the accuracy of the Surveyor's findings nor the conclusions drawn there from. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied. **1.** Facility will attain proper authorization before releasing medical records from patient/ family/ or legal representative for resident #1. **2.** Record review indicates no other residents found to be affected by the same occurrence. **3.** The facility will attain proper release of information from patient/ family/ or legal representative before releasing medical records. Health Information, Social Services, and Nursing administration will be in-serviced on proper procedures for releasing medical information.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Hunter Harris — TITLE: Administrator — (X6) DATE: 6/26/12

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 clinical records for one resident (#1) of seven residents reviewed. The findings included: Resident #1 was admitted to the facility on February 27, 2007, and readmitted to the facility on April 14, 2012, with diagnoses including Multiple Sclerosis, Quadriplegia, Depression, Suprapubic Catheter, and Pylonephritis. Medical record review of the Minimum Data Set (MDS) dated September 1, 2011, revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) with intact cognitive skills, no memory impairment, and no behaviors. Medical record review revealed resident #1 was transferred from the facility and admitted to the hospital on April 11, 2012, with diagnoses of Acute Renal Failure and Pyelonephritis. The resident was discharged back to the facility on April 14, 2012, following a three day hospital stay. Medical record review of a Discharge Planner note, from the local hospital, dated April 13, 2012, at 5:40 p.m., revealed "...verbal permission from pts (patients) daughter via phone call...first choice NHC (National Health Care of Athens)..." Interview with the Administrator on May 22, 2012, at 12:05 p.m., in the Administrator's office, confirmed when the resident went to the hospital in April, 2012, the resident's family member did not want the resident admitted to another nursing home facility following the hospital stay, but the facility had previously been in contact with	F 164	**4.** Administrator/designee will review with Social Services Department Head to ensure proper procedures were followed for the release of medical records for patients that transferred out of the facility once a month for three months. Findings will be reported at the monthly QA meeting attended by Administrator, DON, ADON, Social Services, and Medical Director.	6/30/12

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F 164	Continued From page 2 another nursing home facility regarding possible placement at the other facility. Interview with the Social Service Director on May 22, 2012, at 4:45 p.m., in the Social Service office, confirmed the resident's clinical information had been faxed to another local nursing home on April 13, 2012, for possible placement in the other facility, and neither the resident nor family had not requested or given permission for clinical information to be sent. C/O #29799	F 164		
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced	F 205	**1.** Resident #1/ family/ legal representative will be given a phone call followed by a written notice of the bed-hold policy within twenty-four hours of a future transfer to the hospital. **2.** Record review indicates no other patients were found to be affected by the same occurrence. **3.** When patients are transferred to the hospital, the patient/ family/ or legal representative will be given a phone call followed by a written notice of the bed-hold policy within twenty-four hours of admission to the hospital. **4.** Administrator/designee will review all transfers to the hospital monthly to ensure that a phone call followed by a written twenty-four hour notice of bed-hold policy was sent to the patient/ family/ or legal representative for three months. Findings will be reported at the monthly QA meeting attended by Administrator, DON, ADON, Social Services, and Medical Director.	6/30/12

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F 205	Continued From page 3 by: Based on medical record review, review of facility documentation, and interview, the facility failed to provide written notice of the bed-hold policy within twenty-four hours of a transfer for one resident (#1) of seven residents reviewed. The findings included: Resident #1 was admitted to the facility on February 27, 2007, and readmitted to the facility on April 14, 2012, with diagnoses including Multiple Sclerosis, Quadriplegia, Depression, Suprapubic Catheter, and Pylonephritis. Medical record review of the Minimum Data Set (MDS) dated September 1, 2011, revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) with intact cognitive skills, no memory impairment, and no behaviors. Medical record review revealed resident #1 was transferred from the facility and admitted to the hospital on April 11, 2012, with diagnoses of Acute Renal Failure and Pyelonephritis. The resident was discharged back to the facility on April 14, 2012, following a three day hospital stay. Medical record review and review of facility documentation revealed no documentation the resident or the resident's representative had been given written notice of the facility's bed-hold policy within 24 hours of admission to the hospital. Interviews with the Social Service Director on May 22, 2012, at 4:15 p.m., and 4:45 p.m., in the Social Service office, confirmed a family member	F 205		

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F 205	Continued From page 4 of the resident was notified verbally by the Administrator the resident had no bed hold days, after the resident was admitted to the hospital. Interview with the Administrator on May 23, 2012, at 12:05 p.m., in the Administrator's office, confirmed the facility failed to provide a written notice within twenty-four hours of transfer to the hospital of the bed hold policy. C/O #29799	F 205	1. All equipment used with Resident #1, is currently in prime working condition. If equipment is found to be malfunctioning, a work order will be filled out immediately and Administrator or designee will be notified. The DME Company will be notified to reserve backup equipment until malfunctioning equipment is repaired. 2. No other patients were found to be affected by the same occurrence. 3. Staff will be in-serviced on the proper procedure for filling out work orders when equipment is malfunctioning. Any issues concerning equipment malfunction and accommodation of needs will be discussed at the weekly interdisciplinary meeting attended by Administrator, DON, ADON, Social Services Director, and Dietary. 4. Administrator/ DON/ designee will review any work orders concerning equipment malfunction in the weekly interdisciplinary meeting attended by Administrator, DON, ADON, Social Services Director, and Dietary.	6/30/12
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to accommodate individual needs for one resident (#1) of seven residents reviewed. The findings included: Resident #1 was admitted to the facility on February 27, 2007, and readmitted to the facility on April 14, 2012, with diagnoses including Multiple Sclerosis, Quadriplegia, Depression, Suprapubic Catheter, and Pylonephritis.	F 246		

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F 246	Continued From page 5 Medical record review of the Minimum Data Set (MDS) dated September 1, 2011, revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) with intact cognitive skills, no memory impairment, and no behaviors. Continued review of the MDS revealed the resident required total staff assistance for all transfers, eating, and activities of daily living (ADLS). Medical record review of an Interdisciplinary Care Plan, dated May 10, 2012, revealed "...dependent on staff for ADLS r/t (related to) quadriplegia secondary to Multiple Sclerosis...resident will have all daily needs for ADL, met by staff...two person transfer w/ (with) total body lift to electric w/c (wheelchair) with chin control for mobility, tv (television) controls and computer access...total assist of two persons for toileting and position changes in bed and w/c...staff to totally assist with meals daily...reposition frequently as pt (patient) is unable to make even slight changes unassisted...residents needs and wants will be met daily without excess demands..." Interview with the resident on May 22, 2012, at 9:10 a.m., and 3:40 p.m., in the resident's room, revealed the Maxi Lift (mechanical lift resident needed to be moved from bed to chair and chair to bed) had broken on May 12, 2012, and had not been repaired until May 17, 2012. Further interview revealed the resident's electric chair would recline for sleeping and the resident stayed in the electric wheelchair from May 12, through May 17, 2012. Further interview revealed the resident did not use a facility supplied bed or mattress; the height of the resident's personal bed did not adjust and the Arjo lift (the facility's	F 246		

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F 246	Continued From page 6 other mechanical lift) did not go up high enough to place the resident in the resident's bed. Further interview revealed the Administrator offered on the third or fourth day to change the resident's bed to a facility supplied bed, and the resident requested the resident's mattress be placed on the facility bed, but staff never changed the bed. Further interview confirmed the resident had not been offered another alternative. Interview with Certified Nurse Assistant (CNA) #1 on May 22, 2012, at 2:45 p.m., in the Nurse's Station, revealed the resident had been in the electric wheelchair from May 12, 2012, through May 17, 2012, and had not been placed in the resident's bed at night due to the Arjo Lift would not raise the resident high enough to place the resident on the resident's bed. Continued interview revealed the Arjo Lift would allow the staff to provide all ADLS the only change in routine care from May 12, 2012, through May 17, 2012, was the resident was not able to lie down on the resident's bed. Interview with Licensed Practical Nurse (LPN) #1 on May 22, 2012, at 3:15 p.m., in the Activity Room, confirmed the Maxi Lift broke on May 12, 2012, at 3:00 p.m., and was not operational until May 17, 2012, sometime in the morning. Further interview revealed the facility attempted to contact the Administrator and the Maintenance Director regarding the broken Maxi Lift and did not receive a return call on May 12 or May 13, 2012. Further interview confirmed the broken mechanical lift was the lift required to put resident #1 to bed, the resident was not offered any alternatives (manual lift or bed options) over the weekend and the resident stayed up in the electric wheelchair from	F 246		

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F 246	Continued From page 7 May 12 through May 17, 2012. Interview with CNA #2 on May 23, 2012, at 9:15 a.m., in the Conference Room, revealed the Maxi Lift was broken when the CNA arrived at work on May 14, 2012, staff reported to the CNA the Maxi Lift had been broken since May 12, 2012, and the resident had been in the chair since May 12, 2012. Continued interview revealed the Arjo Lift had been in place, staff had been using the Arjo Lift to provide routine care, and the Arjo Lift would not raise the resident high enough to place the resident on the resident's bed. Further interview confirmed, on May 15, 2012, the Administrator offered to change the resident's bed to a facility bed so the resident could lie down, and the resident requested own personal mattress be placed on the facility bed, but nothing had been changed. Interview with CNA #3 on May 22, 2012, at 3:05 p.m., in the Activity Room, confirmed the resident required total care, while the Maxi Lift was broken the resident stayed in the electric chair all day, staff repositioned the resident, staff performed routine care with the Arjo Lift, but staff had not been able to lie the resident down in bed. Interview with the Administrator on May 22, 2012, at 11:30 a.m., in the Administrator's office, confirmed the mechanical lift was broken May 12, through 17, 2012, the resident had stayed in the chair without going to bed from May 12, 2012, through May 17, 2012, and the facility did not accommodate the resident's needs for five days.	F 246		
F 250	C/O #29799 483.15(g)(1) PROVISION OF MEDICALLY	F 250		

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F 250 SS=D	Continued From page 8 RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, interview, and review of facility investigation, the facility failed to provide Social Services adequate to meet the needs of two (#1, #5) residents of seven residents reviewed. The findings included: Resident #1 was admitted to the facility on February 27, 2007, and readmitted to the facility on April 14, 2012, with diagnoses including Multiple Sclerosis, Quadriplegia, Depression, Suprapubic Catheter, and Pylonephritis. Medical record review of the Minimum Data Set (MDS) dated September 1, 2011, revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) with intact cognitive skills, no memory impairment, and no behaviors. Continued review of the MDS revealed the resident required total staff assistance for all transfers, eating, and activities of daily living (ADLS). Medical record review of an Interdisciplinary Care Plan, dated May 10, 2012, revealed "...dependent on staff for ADLS r/t (related to) quadriplegia	F 250	**1.** Social Services Director has met with Resident #1 to discuss any psychosocial issues or concerns. Resident #5 is no longer a patient at this facility. **2.** No further patients were affected by the same occurrence. **3.** In weekly interdisciplinary meeting all clinical and psychosocial issues or concerns will be discussed. **4.** Administrator/ DON and Social Service Director/designee will monitor psychosocial issues or concerns to ensure patient's needs are met with Social Service intervention and findings will be discussed at the weekly interdisciplinary meeting attended by Administrator, DON, ADON, Social Services Director, and Dietary.	6/30/12

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F 250	Continued From page 9	F 250		

secondary to Multiple Sclerosis...resident will have all daily needs for ADL, met by staff...provide oral care...two person transfer w/ (with) total body lift to electric w/c (wheelchair) with chin control for mobility, tv (television) controls and computer access...total assist of two persons for toileting and position changes in bed and w/c...unable to utilize hand toggle switch independently...staff to totally assist with meals daily...reposition frequently as pt (patient) is unable to make even slight changes unassisted...residents needs and wants will be met daily without excess demands...meet residents needs and wants as much as possible but set limits...tell (resident)...how many minutes may be spent before beginning, that you may return later if needed, whether care can be done as (resident) requests...Inappropriate Behavior AEB (as exemplified by) attempted manipulation and control of staff and family, demanding and impatient, verbally sharp w/ caregivers...Anxiety AEB easily frustrated, repetitive health complaints, anxious concerns, insomnia, unpleasant mood in the mornings, social isolation..."

Medical record review revealed no Social Services Notes from January 2012, through May 22, 2012, related to any concerns, meetings, or needs.

Observation of the resident on May 22, 2012, at 9:10 a.m., in the resident's room, revealed the resident in an electric wheelchair, with chin control for television control, call light, remote fan, computer with whisper software, and head piece for volume. Interview with the resident, at this time, confirmed the resident had expressed

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F 250	Continued From page 10 concerns and had meetings with the facility Administration related to personal care not being provided and the facility not meeting the resident's needs or addressing the resident's concerns. Continued interview confirmed the Social Worker of the facility had not visited with the resident or attended any meetings discussing the resident's concerns related to personal care and concerns. Interview with the Social Service Director on May 22, 2012, at 4:45 p.m., in the Social Service office, confirmed the Social Worker had been aware of the facility meetings with the resident regarding the resident and family concerns related to the resident's care; the facility informing the resident and the resident's family the facility was recommending discharge home or other placement; and the facility's refusal to take the resident back after a transfer to the hospital. Continued interview at this time confirmed the Social Worker had not had any contact with the resident or provided any services to the resident, "Administrator had handled the situation." Interview with the Administrator and the Senior Regional Vice President on May 23, 2012, at 10:00 a.m., in the conference room, confirmed the resident had concerns and issues the facility was attempting to resolve, and the resident had psychosocial issues and could benefit from social services interventions, but no social services consult or interventions had been completed. Resident #5 was admitted to the facility on June 29, 2011, with diagnoses including an Ileus, Alzheimer's Disease, Anxiety, and Cirrhosis.	F 250		

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F 250	Continued From page 11 Review of a facility investigation dated May 16, 2012, revealed an allegation of physical abuse had occurred in the facility on May 15, 2012, at 6:00 p.m., in which resident #5 was being fed by a family member. It was alleged the family member "...slapped (the resident) in the face..." in an attempt to wake the resident, so the family member could feed the resident the evening meal. Interview with the Social Worker on May 23, 2012, at 10:00 a.m., outside the Social Worker's office, confirmed the incident had been investigated by the Administrator and the Social Worker had not been involved with the investigation and had not contacted the resident or the resident's family related to the allegation of physical abuse to assess for any psychosocial needs or interventions that could be beneficial. Interview with the Administrator on May 23, 2012, at 10:15 a.m., in the conference room, confirmed the facility failed to initiate a Social Services consultation/case review for the resident related to the allegation of physical abuse to assess the resident and offer any psychosocial interventions. C/O #29799 C/O #29814	F 250		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide oral hygiene for one resident (#1) of seven residents reviewed. The findings included: Resident #1 was admitted to the facility on February 27, 2007, and readmitted to the facility on April 14, 2012, with diagnoses including Multiple Sclerosis, Quadriplegia, Depression, Suprapubic Catheter, and Pylonephritis. Medical record review of the Minimum Data Set (MDS) dated September 1, 2011, revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) with intact cognitive skills, no memory impairment, and no behaviors. Continued review of the MDS revealed the resident required total staff assistance for all transfers, eating, and activities of daily living (ADLS). Medical record review of an Interdisciplinary Care Plan, dated May 10, 2012, revealed "...dependent on staff for ADLS r/t (related to) quadriplegia secondary to Multiple Sclerosis...resident will have all daily needs for ADL, met by staff...provide oral care...residents needs and wants will be met daily without excess demands...meet residents needs and wants as much as possible but set limits...tell (resident)...how many minutes may be spent before beginning, that you may return later if needed, whether care can be done as (resident)	F 312	**1.** DON/ designee will ensure that Resident #1 has oral care daily. **2.** No other patients were found to be affected by the same occurrence. **3.** Staff will be in-serviced on daily oral care for all residents. DON/ designee will monitor 10% of patients monthly for three months. **4.** Social Services Director will meet with Resident #1 once a week for 8 weeks to discuss issues or concerns and findings will be reviewed weekly in the interdisciplinary meeting attended by Administrator, DON, ADON, Social Services Director, and Dietary.	6/30/12

JUN 29 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445099	A. BUILDING _____ B. WING _____	C 05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 312	Continued From page 13 requests..." Interviews with the resident on May 22, 2012, at 9:10 a.m., and 3:30 p.m., in the resident's room, revealed the the resident stated "...staff do not brush my teeth everyday...they run out of time..." Further interviews confirmed the resident's teeth were brushed on May 22, 2012, by Certified Nursing Assistant (CNA) #2 and a student, but there were days when the resident's teeth did not get brushed because the CNAs did not have time. Interviews with CNA #1 on May 22, 2012, at 2:45 p.m., at the nurse's station, with CNA #4 on May 22, 2012, at 3:05 p.m., at the nurse's station, and with Licensed Practical Nurse #1 on May 22, 2012, at 3:15 p.m., at the nurse's station, confirmed the resident's personal care took longer to perform than other residents and staff frequently had to limit the amount of time spent performing the resident's care in order to complete other tasks and care for other residents. Interview with CNA #2 on May 23, 2012, at 9:15 a.m., in the conference room, confirmed the resident's personal care took longer to perform than other residents and the resident's teeth did not get brushed daily. Interview with the Regional Vice President on May 23, 2012, at 10:00 a.m., in the conference room, confirmed expectations of the staff would be to brush the resident's teeth at a minimum once daily.	F 312		
F 456 SS=D	C/O #29799 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	F 456		

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F 456	Continued From page 14 The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure equipment required to transfer a resident was maintained in working condition for one resident (#1) of seven residents reviewed. The findings included: Resident #1 was admitted to the facility on February 27, 2007, and readmitted to the facility on April 14, 2012, with diagnoses including Multiple Sclerosis, Quadriplegia, Depression, Suprapubic Catheter, and Pylonephritis. Medical record review of the Minimum Data Set (MDS) dated September 1, 2011, revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) with intact cognitive skills, no memory impairment, and no behaviors. Continued review of the MDS revealed the resident required total staff assistance for all transfers, eating, and activities of daily living (ADLS). Medical record review of an Interdisciplinary Care Plan, dated May 10, 2012, revealed "...dependent on staff for ADLS r/t (related to) quadriplegia secondary to Multiple Sclerosis...resident will have all daily needs for ADL, met by staff...two person transfer w/ (with) total body lift to electric	F 456	**1.** If equipment is found to be malfunctioning, a work order will be filled out immediately and Administrator or designee will be notified. The DME Company will be notified to reserve backup equipment until malfunctioning equipment is repaired. **2.** No other patients were found to be affected by the same occurrence. **3.** Staff will be in-serviced on the proper procedure for filling out work orders when equipment is malfunctioning. Any issues concerning equipment malfunction and accommodation of needs will be discussed at the weekly interdisciplinary meeting attended by Administrator, DON, ADON, Social Services Director, and Dietary. **4.** Administrator/ DON/ designee will review any work orders concerning equipment malfunction in the daily morning meeting attended by Administrator, DON, ADON, Social Services Director, and Dietary.	6/30/12

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F 456	Continued From page 15 w/c (wheelchair)...total assist of two persons for toileting and position changes in bed and w/c...reposition frequently as pt (patient) is unable to make even slight changes unassisted...residents needs and wants will be met daily without excess demands..." Interview with the resident on May 22, 2012, at 9:10 a.m., and 3:40 p.m., in the resident's room, revealed the Maxi Lift (mechanical lift resident needed to be moved from bed to chair and chair to bed) had broken on May 12, 2012, and had not been repaired until May 17, 2012. Further interview revealed the resident's electric chair would recline for sleeping and the resident stayed in the electric wheelchair from May 12, through May 17, 2012. Further interview revealed the resident did not use a facility supplied bed or mattress; the height of the resident's personal bed did not adjust and the Arjo lift (the facility's other mechanical lift) did not go up high enough to place the resident in the resident's bed. Interview with the Maintenance Director on May 22, 2012, at 11:00 a.m., in the maintenance office, confirmed a verbal request to repair the Maxi Lift, which had been broken, was received by the Maintenance Director on one day (unknown which day) and the lift had been fixed the next day. Further interview confirmed no written order had been completed by the staff and no purchase order had been completed by the Maintenance Director. Interview with Certified Nurse Assistant (CNA) #1 on May 22, 2012, at 2:45 p.m., in the Nurse's Station, revealed the resident had been in the electric wheelchair from May 12, 2012, through	F 456		

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F 456	Continued From page 16 May 17, 2012, and had not been placed in the resident's bed at night due to the Arjo Lift would not raise the resident high enough to place the resident on the resident's bed. Continued interview revealed the Arjo Lift would allow the staff to provide all ADLS the only change in routine care from May 12, 2012, through May 17, 2012, was the resident was not able to lie down on the resident's bed. Further interview confirmed three other residents did not receive their normal care due to the lift being broken. Interview with Licensed Practical Nurse (LPN) #1 on May 22, 2012, at 3:15 p.m., in the Activity Room, confirmed the Maxi Lift broke on May 12, 2012, at 3:00 p.m., and was not operational until May 17, 2012, sometime in the morning. Further interview revealed the facility attempted to contact the Administrator and the Maintenance Director regarding the broken Maxi Lift and did not receive a return call on May 12 or May 13, 2012. Further interview confirmed the broken mechanical lift was the lift required to put resident #1 to bed, the resident was not offered any alternatives (manual lift or bed options) over the weekend and the resident stayed up in the electric wheelchair from May 12, 2012 through May 17, 2012. Interview with CNA #2 on May 23, 2012, at 9:15 a.m., in the Conference Room, revealed the Maxi Lift was broken when the CNA arrived at work on May 14, 2012, staff reported to the CNA the Maxi Lift had been broken since May 12, 2012, and the resident had been in the chair since May 12, 2012. Continued interview revealed the Arjo Lift had been in place, staff had been using the Arjo Lift to provide routine care, and the Arjo Lift would not raise the resident high enough to place the	F 456		

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F 456	Continued From page 17 resident on the resident's bed. Interview with CNA #3 on May 22, 2012, at 3:05 p.m., in the Activity Room, confirmed the resident required total care, when the Maxi Lift was broken the resident stayed in the electric chair all day, staff repositioned the resident, staff performed routine care with the Arjo Lift, but staff had not been able to lie the resident down in bed. Interview with the Administrator on May 22, 2012, at 11:30 a.m., in the Administrator's office, confirmed the mechanical lift was broken May 12, through 17, 2012, two residents in the facility required use of the broken lift, and all equipment in need of repair was to be reported immediately to the Maintenance Director for repair. C/O #29799	F 456		